Consultation Draft: October 3, 2008

Michigan Department of Community Health
Mental Health and Substance Abuse Administration

FOCUSING A PARTNERSHIP FOR RENEWAL AND RECOMMITMENT TO QUALITY AND COMMUNITY IN THE MICHIGAN PUBLIC MENTAL HEALTH SYSTEM

APPLICATION

Meeting the Challenge:

This Application for Renewal and Recommitment (ARR) formally introduces new and enhanced dimensions of performance, and revitalizes our commitment to excellence in the priorities and directions outlined in the August 12th Concept Paper. This ARR further executes the 2000 Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans, approved by the federal Centers for Medicare and Medicaid Services (CMS), that promised Michigan would select local managing entities that promote beneficiary freedom, participation and integration, while achieving system outcomes of efficiency, choice and community inclusion.

The standards herein were designed to better reflect the current expectations of the public mental health service recipients and other stakeholders to support choice-driven outcomes. Partnerships with people who receive services and their supporters (families, friends and advocates) are crucial to successful recommitment. The Michigan Department of Community Health (MDCH) has therefore established goals for improving their involvement and participation in local planning, implementation and evaluation of services. Similarly, other community partners, such as providers and local businesses, need to be engaged if there is to be a successful local establishment of an effort that can ultimately achieve the elements of MDCH's vision outlined in the Concept Paper.

The ARR stresses the importance of the Pre-paid Inpatient Health Plans (PIHPs) supporting greater personal autonomy, control and direction of the course of people's lives that require assistance from the public mental health system. The ARR asks PIHPs to further recommit to finding the best ways to assure that those with the greatest vulnerabilities and the least capacity to advocate for themselves are supported in ways that celebrate their humanity and recognize their right to a life with meaning and personal dignity. MDCH expects that PIHPs will join us in moving toward zero-tolerance for poor care and for supports that do not recognize and celebrate personal dignity and self-worth.

With this ARR, MDCH invites the PIHPs and Community Mental Health Services Programs (CMHSPs), along with individuals receiving services, their supporters, and other community partners, to set a course together that achieves certain goals over a five-year period. The major focus of this multi-year effort is to improve the quality and appropriateness of care such that the people served by the public mental health system are supported to achieve true community membership. A secondary focus is to achieve administrative efficiencies that

ease the planning for and provision of supports and services and preserve funds for reinvestment during these difficult times.

Application

The ARR that follows is directed at existing PIHPs. The ARR identifies "dimensions of performance" that include new and enhanced standards, as well as developmental standards, for the specialty services and supports program. The ARR requests responses from applicant PIHPs that indicate they either meet a particular standard as of January 2009, or they have a plan for meeting the standard within five years. If the applicant is able to answer that they fully meet the standard, MDCH expects that they will, however, continue to engage in quality improvement efforts. Some dimensions of performance will evolve to standards over the next five years. Examples are culture of gentleness, trauma and active engagement. For these concepts, all applicants will be expected to develop a plan for meeting the standards as they evolve. MDCH approval of responses from each applicant PIHP will constitute approval to contract with that PIHP beginning October 1, 2009. Individual PIHP as well as statewide performance objectives will also be developed as a result of MDCH review of the ARR responses and subsequent discussions with each PIHP. The performance objectives will be incorporated in the FY 10 MDCH/PIHP contracts, and will be monitored by MDCH. Just as the AFP was attached in whole to the MDCH/PIHP contracts and monitored by MDCH, so will be the ARR.

Relationship to PPGs

The Program Policy Guidelines (PPGs), to be issued simultaneously with the ARR, will request the CMHSPs to submit data to MDCH on certain key areas that were addressed in the Concept Paper. It is expected that applicant PIHPs will work with their affiliate CMHSPs, as applicable, to aggregate and review that data and develop PIHP-wide continuous quality improvement plans in response to the ARR. For that reason, there are few requests for data to be submitted to MDCH contained in this ARR.

Relationship to External Quality Review

An annual external quality review (EQR) of all Medicaid managed care organizations is required by the federal Balanced Budget Act (BBA) at 42 CFR 438.358. MDCH contracts with an external quality review organization to conduct that activity. Issues addressed by the Concept Paper that are already covered by the EQR will not require further attention in the response to the ARR. However, MDCH does expect that the PIHP is in substantial compliance with the BBA standard, and therefore will consider the results of the most recent EQR in its determination of whether the applicant is adequately addressing the relevant Concept Paper issues. Where relevant, MDCH has identified the BBA standards that relate to the ARR section.

Relationship to the Application for Participation

The 2002 Application for Participation (AFP) established a set of standards for the Medicaid specialty services and supports program. The AFP was added as an attachment to the MDCH/PIHP contracts. Issues addressed by the Concept Paper that are already covered by

the standards in the AFP will not require further attention in the response to the ARR. However, MDCH does expect that the PIHP is in substantial compliance with the AFP standards. Some issues in the concept paper require enhancements and improvements to AFP elements. As such, those are incorporated in the Dimensions of Performance in each section of the ARR. Where relevant, MDCH has identified the AFP elements that relate to the ARR section.

Relationship to the MDCH/PIHP Contract, Mental Health Code and Medicaid Provider Manual

Some issues in the Concept Paper are already addressed by MDCH/PIHP contract, Mental Health Code, or Medicaid Provider Manual. In those cases, the ARR will not require further attention in the applicant's response, however it is expected that the PIHP is in substantial compliance with them.

Note: This draft ARR contains proposed standards for the applicants to meet over time. The final ARR will require that the applicants verify that they meet certain standards as of January 2009 and have the documentation or evidence that the final ARR will explicate; or that they have a plan to meet the standards within five years. Some concepts have proposed standards that are in a developmental phase, and therefore the final ARR will request that the applicants begin developing plans as MDCH works with all stakeholders to fully develop the standards.

1. Partnering with Stakeholders in the Design, Delivery and Evaluation of the Public Mental Health System

Inherent in the success of the renewal and recommitment to quality and community in Michigan's public mental health system is partnering with stakeholders in its design, delivery and evaluation. Since 1974, Michigan CMHSPs are required by law to include primary consumers and family members of primary consumers on their boards. For more than a decade, CMHSPs and PIHPs have been contractually required to have consumer advisory committees to provide input on various functions, especially the quality management processes. Yet, MDCH has heard criticism that these opportunities for involvement are limited in their scope and meaningfulness, and often are limited to a small select group of stakeholders who do not require support or accommodation for their participation. The time has come to improve the breadth and depth of stakeholder "involvement."

It is MDCH's expectation that individuals who receive services, their supporters (family, friends, and advocates), providers, and other interested groups will be partners at the state level, and with PIHPs, CMHSPs and their providers not only in this comprehensive quality improvement undertaking, but continuously over time. MDCH challenges the applicant PIHPs to develop innovative methods to recruit, support and retain stakeholders; and to develop ways to involve stakeholders so that they feel their participation is meaningful. Further, MDCH expects that the applicant PIHP's partners will represent the rich diversity of its communities. Finally, MDCH encourages applicant PIHPs to consider local small business owners as well as corporation executives as potential long-term partners.

Dimensions of Performance

1. *The applicant, and its CMHSP affiliates as applicable, is implementing a plan for increasing the involvement of individuals who receive services, and their supporters (family, friends and advocates) in all aspects of the design, delivery and evaluation of the supports and services that the applicant and its network provide.*

MDCH expects that PIHPs will continue to be in substantial compliance with the standards relevant to this section including, the **AFP (see** 1.7 Consumer/stakeholder involvement, 2.1 Stakeholder and Community Input, 3.9 Quality Management) and **other Medicaid, Mental Health Code and Contract requirements.**

2. Improving the Culture of Systems of Care

As articulated in the Customer Services Standards and the Access Standards, public mental health agencies must assure a welcoming and caring culture where individuals who come to the door or who are already served are treated with respect and dignity. They are provided with access to complete information about service array, provider options, costs of services, and rights and due processes. There must be zero tolerance for applicants or individuals receiving services to be ignored and/or rudely addressed.

A "culture of gentleness" must be fostered wherein force is not used to subdue individual's responses of resistance and threat to current experience. Force cannot be the intervention of choice to deal with an individual's expression of frustration and pain. Instead, the emphasis must be on developing skills for assessing the antecedents of challenging behavior, for identifying clinical factors, and to rule out physical, medical, environmental, and trauma-based conditions that might be the cause of the behaviors. There must be broad understanding of ways to interpret behavior as communication about that person's experience. There must be expanded training and guidance that encourages and enables staff to respond to people with understanding and compassion, rather than fear or condemnation, and to provide positive support for those who must express their needs through challenging behavior.

Public mental health staff will better perform to support those with intensive needs if they work within a trauma-informed system of supports and avoid the stigma that those who are paid to conduct their work can communicate to co-workers and the people they serve. All must learn to recognize and understand how past experiences of trauma and stigma invade the lives of those requiring support, driving many to act out of desperation and in defense of themselves. Understanding the long-range impact of major trauma and the indelible marks that are left on one from traumatic experiences can assist those in clinical and supportive roles with improving effectiveness. Being trauma-informed means imbuing a personal awareness in those providing services of the ways that their interactions and interventions may inadvertently re-invoke a trauma experience for an individual. With awareness, they can more successfully assure support and safety for all. Learning to be vigilant for signs of trauma and understanding the positive responses that provide an environment of protection and support must become basic in staff capacities at all levels.

Children with Serious Emotional Disorder (SED) and children with a developmental disability and their families must be the focus of specific effort to foster and promote resiliency factors. These factors are research-based and can be used as a framework for encouraging skill development competences. The vital role family resiliency plays in increasing individual resiliency in children must be recognized. Building an effective system of care that promotes resiliency must also include informal and formal support systems working together effectively.

To ensure better outcomes for children and their families, a community system of care is developed. A system of care for children/youth and their families is defined as the organization of public and private services within the community into a comprehensive and

interconnected network in order to accomplish better outcomes for all children (infants, toddlers, children, youth and their families. To that end, all partners (stakeholders) need to be actively engaged in the analysis and the ongoing planning and evaluation for the system of care. It is anticipated that the development of a system of care will lead to improved access to an array of community-based mental health services for children/youth with SED and developmental disabilities.

Efforts by persons with mental illness to pursue a pathway toward recovery must be supported by a public mental health system that fosters a culture which recognizes and values recovery as a central component of treatment and support. Elements of recovery involve the projection of hope and the expectation of recovery, not discouragement, toward persons with mental illness histories, no matter their current status. The elements include recognizing and moving away from identifying those receiving services as "cases" and other responses that objectify individuals. They include increasing personal knowledge of and approaches to addressing illness through adherence to health-promoting activities that assist resiliency, as well as those which invoke sanctuary when that is needed. Recovery culture begins with a belief that recovery is possible, worthwhile and achievable for virtually everyone, over time. CMHSPs and PIHPs will be expected to apply the Recovery Enhancing Environment Measure as part of their planning, as a method to gauge and promote local awareness of how current operations support or inhibit opportunity for recovery.

Development of a culture of recovery must include expansion of a culture that resists and reduces the stigma associated with those who possess a mental illness label. While it needs to become a community campaign to replace publicly-held perceptions and beliefs, reducing stigma and its impact starts within the culture of the public mental health system. No effort to address stigma can ignore the fact that stigma underlies many of the day-to-day ways that those paid to plan, manage and provide services choose to conduct their work. Finally, the public mental health agency will be culturally competent to meet the diverse needs of the local citizens, including individuals who have hearing impairments.

Dimensions of Performance

Welcoming

1. *The applicant, and its CMHSP affiliates as applicable, ensures a welcoming atmosphere, physical comfort and emotional safety for the people served throughout its array of services and supports.*
    a. *Evidence:*
        i. *The applicant has a methodology for obtaining consumer feedback on its welcoming atmosphere and for making changes based on this feedback.*
        ii. *The applicant routinely conducts a specific and systematic review, with input from service recipients, regarding the physical settings (e.g., waiting rooms, program locations and physical environments) in which services and supports are offered and make improvements as needed.*

iii. *The applicant has concrete standards and practice experience that demonstrates it provides opportunity for sufficient time and support so that an individual making contact will be able to express and explore their situation and circumstances.*
iv. *The applicant routinely reviews customer complaints to determine if there are any about a lack of welcoming, and makes changes to prevent their recurrence.*
v. *Individuals, when surveyed, report that they are satisfied with program environments, safety and welcoming atmosphere.*

Creating a Culture of Gentleness

2. *Using data from the CMHSP's and the affiliate CMHSPs' as applicable, response to the PPGs, the applicant has identified the responsible leader(s) and employs a plan for developing, implementing, monitoring and continuously improving the effort to support a "culture of gentleness" within the organization and its network of service and support providers. At a minimum, the plan includes a process that:*
    a. *Identifies current capacities, unmet needs and areas needing development and improvement.*
    b. *Develops skills of direct care and professional staff to implement a "gentle care approach" to service planning and delivery.*
    c. *Routinely identifies individuals who have characteristics that may cause them to be labeled as "individuals with difficult behaviors."*
    d. *Reviews and makes needed changes in person-centered planning processes that rule out physical, medical, environmental, interpersonal and trauma-based conditions that might be the cause of the behaviors.*

Trauma

3. *The applicant, and its affiliate CMHSPs as applicable, has adopted a formal policy statement about the importance of recognizing the role of trauma in individuals' experiences, and to take that into account in all aspects of all program operations.*
4. *The applicant has identified the responsible leader(s) and utilizes a plan for developing, implementing, monitoring and continuously improving the effort to support a trauma-informed system of care.*
5. *The applicant, and its affiliate CMHSPs as applicable, has formal policies and procedures that reflect an understanding of trauma that includes, but is not limited to:*
    a. *A consistent way to identify individuals who have been exposed to trauma and to include trauma-related information in planning services with them.*
    b. *Procedures for inquiring about and respecting individual preferences for responding in crisis situations.*
    c. *Assurances that each person is asked about crisis preferences, and their responses are available to all appropriate direct service staff.*

d. A written de-escalation policy that minimizes the possibility of re-traumatization, and includes reference to an individual's statement of preference for crisis response.

Stigma

6. *The applicant has engaged its provider network, together with individuals receiving services, their families and other stakeholders, to identify and discuss the prevalence and type of stigma individuals with developmental disabilities, mental illness or SED face within the public mental health system and the community at large. Based on this information, the applicant is implementing a plan to address stigma within its own organization, its affiliation as applicable, provider networks, and the community at large.*

Recovery

7. *Based on data gathered in the PPGs, the applicant is implementing the Recovery Enhancing Environment (REE) Scale throughout its service area.*
8. *The applicant is implementing its quality improvement process plan to use the information obtained through the REE to make needed improvements identified through the REE process.*
9. *Based on data gathered in the PPGs, the applicant is implementing a plan that ensures an adequate work force of certified peer support specialists so that all adults with mental illness are offered the opportunity to choose and receive services and supports from a certified peer support specialist. All staff who provide services to adults with serious mental illness receive training in recovery.*
10. *The applicant has independent person-centered planning facilitators who have received training in recovery.*

Resiliency for Children with SED or a Developmental Disability

11. *The applicant ensures that programs for children in its service area promote resiliency factors.*
12. *The applicant, and its CMHSP affiliates as applicable, ensures that there are policies and procedures for:*
    a. Incorporating resilience factors in the skill development goals or objectives in the individualized plan of service.
    b. Discussing resiliency factors in the initial assessment of a child.
13. *The applicant, and its CMHSP affiliates as applicable, supports collaboration with the formal service system and informal supports that promote and contribute to child and family resiliency.*
14. *The applicant, and its CMHSP affiliates as applicable, ensures that policy and procedures promote the use of formal and informal supports in the interventions/service plans.*

Children's System of Care

15. *The applicant, along with its CMHSP affiliates as applicable, routinely convenes stakeholders to engage the development of a system of care for children with SEDand for children with developmental disabilities.*
16. *The applicant, and its CMHSP affiliates as applicable, has developed the system of care plan (with timelines for further development), and has established priorities for action.*
17. *The applicant has an ongoing process to review the plan to identify needs and priorities and take actions to further the development of the system of care so that continuous improvement occurs.*

MDCH expects that PIHPs will continue to be in substantial compliance with existing standards relevant to this section, including the **EQR** (see Standard VI), the **AFP** (see 2.10 Agency Practices/Recovery, 2.5 Accommodations, 3.1.8 Access to Care/Accommodations**), the MDCH/PIHP Contract** (see Customer Services Standards, Attachment 6.3.1.1; Access Standards, Attachment 3.1.1; and the Technical Requirement for Behavior Treatment Plan Review Committees, Attachment 1.4.1) and **other Medicaid and Mental Health Code requirements.**

3. Assuring Active Engagement

For many of the most vulnerable people served by the public mental health system, their ability to communicate preferences, to express their personal goals and to advocate effectively for themselves is *diminished*. These individuals live with ongoing and critical need for support and medical care that *may* require (~~s~~) up to 24-hour assistance. Their lives must be supported through active, meaningful engagement, rather than being left to be aimless or thrust into activities that routinely offer a convenience for their caregivers and do not promote their opportunity for meaningful involvement and participation at the highest level of personal capacity and interest. A culture of neglect cannot be allowed to disguise itself as 'personal choice.' In residential care, in supports and activities during the day, and especially where personal relationships are so lacking, individuals with intensive needs and an inability to effectively self-advocate and extricate themselves from uncaring and harmful environments, must have their opportunity and their right to effective and appropriate support with personal dignity overseen and guided with extra effort. MDCH, along with The Standards Group, will develop and promulgate standards for active meaningful engagement that incorporate learning, skills development, treatment, health and other related services that promote and facilitate supported independence, community inclusion and participation, and productivity, including employment and volunteerism.

Staff training and guidance, as well as external oversight, must be strengthened. Opportunities for renewal and extra support for staff who work in these care settings must become priorities for administrators and clinical specialists. Mechanisms for individualized support derived from the principles of person-centered planning and self-determination must be applied. Given the preponderance of persons with mental health system experience among the homeless population, addressing the homeless in the local community is an additional opportunity to actively engage those who are or ought to be supported through the public mental health system.

Dimensions of Performance

1. *The applicant, and its affiliate CMHSPs as applicable, routinely assesses the functional developmental, behavioral, social, health and/or nutritional status, as applicable, of the most vulnerable people it serves to determine what kinds of supports, services and treatment might be offered to improve their quality of life.*
2. *The plans of service of vulnerable individuals:*
    a. *describe the training, health services (including occupational therapy, nutrition, adaptive equipment, etc.), treatment and other supports that will enable them to be actively engaged in a life that is meaningful to them.*
    b. *identify opportunities and supports for people to regularly make choices and decisions that will give meaning to their lives.*
3. *The applicant, and its affiliate CMHSPs as applicable, procures service and support providers for its network who will promote and facilitate active, meaningful engagement for the people they serve.*

4. *The applicant, and its affiliate CMHSPs as applicable, routinely reaches out to, and receives commitments from local organizations, businesses, and other entities who will welcome and support individuals to fully participate in their endeavors.*
5. *The applicant, and its affiliate CMHSPs as applicable, orients all new staff and provides continuing education to all current staff to help them understand the people they serve in the context of their whole lives, not just the characteristics and manifestations of their disabilities, illnesses or disorders.*
6. *The applicant, and its affiliate CMHSPs as applicable, teaches staff who provide direct services (case managers, therapists, direct care workers) how to help individuals develop and achieve goals that will improve their lives through active, meaningful engagement.*
7. *The applicant, and its affiliate CMHSPs as applicable, provides ongoing support to staff who provide direct services through such mechanisms as coaching, mentoring, and annual opportunities for learning and renewal.*
8. *The applicant, and its affiliate CMHSPs as applicable, holds supervisors accountable for assuring that their staff are providing supports and services that promote and facilitate active, meaningful engagement.*
9. *The applicant, and its affiliate CMHSPs as applicable, routinely monitors the provision of supports and services to determine whether they promote and facilitate active meaningful engagement by reviewing the individual plans of service and visiting the settings where supports and services are provided. Quality improvement expectations are put in place and monitored where plans of service or provision of service are found inadequate.*
10. *The applicant, and its affiliate CMHSPs as applicable, has regular interactions with local programs that serve homeless in shelters, women's resource centers, or domestic abuse shelters.*
11. *The applicant, and its affiliate CMHSPs as applicable, has established street outreach programs that assist individuals to accept treatment and to begin the transition from homelessness.*

MDCH expects that PIHPs will continue to be in substantial compliance with the standards relevant to this section including, the **AFP (see** 2.3.4 Care Management and 2.10 Agency Practices) and **other Medicaid, Mental Health Code and Contract requirements.**

4. Supporting Maximum Consumer Choice and Control

Meaningful person-centered planning (PCP) is at the heart of supporting consumer choice and control. When gauging the effectiveness of PCP in meeting this intent, evidence must be derived from knowledgeable consumer experience of PCP. PCP, including access to independent facilitation, must be well-supported in all systems and environments. The PCP process must align resources with expectations, and while natural supports must be considered, they cannot be assumed to supplant what is the responsibility of the public mental health system. All consumers in each CMHSP and across every PIHP must be fully informed of, provided expanding opportunities for, and consistent easy access to arrangements that support self-determination. Direct control over the resources allotted for supports and services allows for the person, with chosen allies, to achieve power to control provider arrangements so that services match personal preferences. Inherent in arrangements supporting self-determination is authority over the use of an individual budget so that the person may achieve efficiency and best value outcomes on their own personal terms. Markers to gauge the effectiveness of local options for assuring quality in the access and use of arrangements supporting self-determination will need to be developed and applied per existing policy. Methods to assure arrangements supporting self-determination for persons using services and supports to respond to mental illness must be clearly defined and made available. Consumers, peers and advocates must be deeply involved in assisting each CMHSP and PIHP to achieve success in these endeavors. Barriers will ultimately be overcome through a willingness to embrace options supporting self-determination; technical guidance will expand from outreach efforts to learn what has worked in other locales.

Dimensions of Performance

Person-centered planning

1. *The applicant, and its CMHSP affiliates as applicable, has a method in place (beyond sharing written information) to assure that individuals understand the PCP process and how to utilize it to develop an individual plan of services.*

2. *The applicant, and its CMHSP affiliates as applicable, offers the assistance of peer support specialists to individuals who are seeking to understand the process and who want others involved in the process.*

3. *The applicant, and its CMHSP affiliates as applicable, makes available the option of independent facilitation of the PCP process for all individuals, except those receiving short-term outpatient services or medications only. The independent facilitators are located in the service area. A list of independent facilitators and their credentials are available for individuals who are pre-planning their PCP process.*

4. *The applicant, and its CMHSP affiliates as applicable, routinely requires that the services and supports appropriate to meet the needs of the individual are discussed during the PCP process.*

5. *The applicant routinely measures the consumer satisfaction with the PCP processes, and the resulting individual plans of services, in its service area, and monitors any quality improvement efforts that are required as a result.*

6. *The applicant, and its CMHSP affiliates as applicable, utilizes methods to assess the strengths and developmental needs by population group for the PCP process. As a result, there is continuous improvement of the knowledge and understanding of, and the consumers' experience with, PCP.*

7. *The applicant, and its CMHSP affiliates as applicable, provides training on the essential elements of the PCP process, as well as systemic and individual indicators, for individuals, staff, contract providers, families and guardians.*

Self-determination

8. *The applicant, and its CMHSP affiliates as applicable, has and utilizes with the people they serve, written policies and procedures, informational materials for individuals, forms and agreements to guide arrangements that support self-determination.*

9. *The applicant, and its CMHSP affiliates as applicable, provides clear information on what an individual budget is and how it is utilized when arrangements that support self-determination are utilized.*

10. *The applicant, and its CMHSP affiliates as applicable, provides a copy of the individual budget and understands how to apply the budget to purchase services and supports to all consumers participating in arrangements supporting self-determination.*

11. *The applicant, and its CMHSP affiliates as applicable, evaluates the level of individual knowledge and awareness of what self-determination is, how it functions in the public mental health system, and how to become involved in methods that support self-determination that are based on consumer feedback.*

12. *The applicant, and its CMHSP affiliates as applicable, provides ongoing self-determination training activities for the individuals they serve, staff, and providers and verifies its effectiveness through feedback from the individual who use self-determination arrangements.*

13. *The applicant, and its CMHSP affiliates as applicable, has contracts with one or more fiscal intermediaries.*

14. *The applicant uses data from the CMHSP and affiliate PPG responses to measure the capacity and effectiveness of self-determination.*

15. *On an ongoing basis, the applicant involves individuals who use self-determination arrangements and their experiences in the development and review of the policy, practice guidelines, implementation practices and training*.

MDCH expects that PIHPs will continue to be in substantial compliance with the standards relevant to this section, including the **EQR** (see Standards VI & VII), **AFP (**see 2.2 and 3.2 Person Centered Planning and 2.11 Self Determination), Person-centered Planning Guideline, Attachment 3.4.1.1; Self-determination Policy and Practice Guideline, Attachment 3.4.3; and Customer Services Standards, Attachment 6.3.1.1 of the **Contract, and other Medicaid and Mental Health Code requirements.**

5. Expanding Opportunity for Integrated Employment

For the past 20 years, employment as a route to both gaining an income and obtaining and enhancing community membership has been a stated goal for each person who depends upon the public mental health system. With employment, one's personal capacity to choose and control one's life direction becomes significantly real. The benefit package offered through the specialty supports and services plan provides many options for supporting the development and maintenance of employment where that is a goal for adults served. Yet, performance in developing supported and integrated employment is uneven, and the numbers of real outcomes are staggeringly small. It is expected that, as one of the highest priorities, public mental health agencies will actively assist adults served to obtain competitive work in integrated settings* and provide the supports and accommodations that are necessary. Partnership with other agencies providing employment supports must be regenerated; involvement of local business must be garnered; and local barriers to employment for persons with mental illness or developmental disability must be explicitly addressed as a community project. System-wide adoption of the evidence-based practices for supported employment for persons with mental illness is an expected achievement across all PIHPs and CMHSPs.

*" Competitive work in integrated settings means work in the community for which anyone (with or without a disability) can apply and pays at least minimum wage."

Dimensions of Performance

1. *The applicant, and its CMHSP affiliates as applicable, has a process in place that assures individuals are given the chance to learn about opportunities for employment and are supported to consider these opportunities during the PCP process.*
2. *The applicant, and its CMHSP affiliates as applicable, has proven partnership(s) with community employers, Michigan Rehabilitation Services (cash match), Intermediate School Districts, Michigan Commission for the Blind, Centers for Independent Living, Michigan Works, employment service providers, temporary services, and/or other agencies.*
3. *The applicant, and its CMHSP affiliates as applicable, has adequate staff who are trained and:*
    - *Charged with job development*
    - *Assigned to assist individuals in retaining supported employment opportunities*
    - *Assigned to assist people with Social Security benefits to understand and use work incentives to start or return to work*
4. *The applicant, and its CMHSP affiliates as applicable, has supported employment services available for adults with serious mental illness which apply the evidence-based practice for Supported Employment*
5. *The applicant, and its CMHSP affiliates as applicable, has programs, especially Clubhouse, Supported Employment, Assertive Community Treatment, Co-occurring*

Disorders Integrated Dual-disorder Treatment that have an active focus on competitive employment.

6. *The applicant, and its CMHSP affiliates as applicable, routinely evaluates the experiences of individuals served in workshop settings to assure they are actively engaged on a daily basis.*
7. *The applicant, and its CMHSP affiliates as applicable, assures that individuals served in workshop settings routinely have opportunities to explore and access community opportunities for employment.*

MDCH expects that PIHPs will continue to be in substantial compliance with the standards relevant to this section, including the **AFP (see** 2.4 Employment) and o**ther Medicaid, Mental Health Code and Contract requirements.**

6. Assuring Opportunity for Needed Treatment for People in the Criminal Justice System

The 2004 Mental Health Commission Report provided several recommendations relative to diversion programs, including more formal understandings of the shared responsibilities of the public mental health system and the judicial system (including law enforcement, defense and prosecuting attorneys, judiciary, corrections and probation). Correspondingly, MDCH, in its Implementation Plan, promoted encouragement of local collaboration and community ownership using the Criminal Justice/Mental Health Consensus Project Report as a blueprint.

The community's joint response to adults with mental illness, children with SED, and individuals with DD who are involved or at risk of involvement with the criminal justice system should be collaborative, informed, competent, and accountable. CMHSPs in many areas are partnering with the justice community in jail diversion, prisoner re-entry, mental health court pilots, and in-jail mental health services. On a statewide basis, progress will come from expanded understanding of successful models and through a focus upon establishing more precise performance standards. The expected collaboration must assure that individuals with SMI are treated rather than simply punished because they are perceived as a public nuisance, even when their offense requires incarceration. This effort must be informed through the inclusion of the perspectives of individuals who have experience with mental illness and justice involvement, and represented by broad local collaboration which best uses the knowledge, skills and financial resources available across both the mental health and justice systems. While there are significant resource allocation issues to be considered in determining priority for services, there is ample evidence that many individuals who now become involved with the criminal justice system also fit within current mental health service priorities.

Dimensions of Performance

Children

1. *The applicant, and its CMHSP affiliates as applicable, has in place signed memoranda of agreements that describe the role of the multi-service collaborative bodies, and outline the partnership, cross-training, and local agency service responsibilities for children involved in the criminal justice system.*
2. *The applicant, and its CMHSP affiliates as applicable, utilizes a mechanism for ongoing review and evaluation of effectiveness that involves the feedback from judges, referees, Department of Human Services, and sheriffs that results in necessary changes being made in mental health services for children and youth.*
3. *All children and youth who are suspected of having a SED or substance use disorder in the criminal justice system are screened to determine their need for mental health and substance abuse treatment services.*

Adults

4. *The applicant, and its CMHSP affiliates as applicable, routinely provides comprehensive data to MDCH that describes the local jail diversion efforts at the individual level.*
5. *The applicant, and its CMHSP affiliates as applicable, has in place signed memoranda of agreements with the local sheriff/jail describing the role and responsibilities of the PIHP/CMHSP in the provision of in-jail mental health services, if any, and community-based inpatient psychiatric mental health treatment of the prisoners.*
6. *The applicant, and its CMHSP affiliates as applicable, utilizes a mechanism for ongoing review and evaluation of effectiveness that involves the feedback from judges, Department of Human Services, and sheriffs that results in necessary changes being made in mental health services for adults.*

MDCH expects that PIHPs will continue to be in substantial compliance with the standards relevant to this section, including the **AFP (**see 2.8.2, 2.8.3 Public Interest) and **other Medicaid, Mental Health Code and Contract Requirements.**

7. Assessing Needs and Managing Demand

This ARR supplements ongoing requirements relative to outreach and access through improvements in assessment of need and in understanding and managing service demand. In general, current methods for assessing the needs of the community and underserved populations fall short of the intent of the Mental Health Code.

The needs of the community must be better determined and the needs, characteristics and interests of un-served and under-served populations must be clearly understood. It is also necessary that the PIHP understand and respond to the implications of service utilization (such as engagement and retention) and evolving best practice requirements.

Gaining a clearer sense of trends in access, utilization and future service demand is important to planning and resource management. Of particular concern is the expected need for intensive services and support by individuals who will arrive at the doors of the public mental health system within 12 months, 24 months, and within five years. Correspondingly, opportunities for effectiveness and savings associated with better outcomes and improved practices must be identified.

Service capacity must be managed in a manner consistent with the Mental Health Code, MDCH policy obligations and in the context of local circumstances. Viable plans must be developed, implemented and monitored to address identified populations and increase access to services.

Dimensions of Performance

1. *The applicant routinely uses data from the annual needs assessment performed by CMHSP, and affiliate CMHSPs as applicable, to develop a plan that includes identification of un-served and underserved Medicaid-eligible individuals and their needs and how these needs will be addressed.*
2. *The applicant annually conducts analyses, planning and practices that identify and appropriately respond to trends in service need and utilization.*

MDCH expects that PIHPs will continue to be in substantial compliance with the standards relevant to this section, including the **EQR** (see Standards V, VII)**, AFP (**see 2.3.1 Care Management, 3.1 Access to Care, and 3.5 Service Array) and **other Medicaid, Mental Health Code and Contract requirements.**

8. Coordinating and Managing Care

Supports coordination and management of care are essential elements of assuring that people with multiple and persistent needs have them addressed successfully. This includes services brokering and access in a system of care where children are involved with the Michigan Department of Human Services (MDHS) for abuse and neglect, or in family foster care. Expanding the application of "System of Care" principles and practices for children and adolescents will be expected, so that those whose involvement cuts across school, MDHS, probate/juvenile court and CMHSP jurisdictions are effectively supported within their families. Supports coordination that can respond to individuals with DD who have complex or at-risk situations exacerbated by the loss of natural caregivers, limited communication skills and having challenging behaviors, and dual diagnoses, cannot be accomplished where caseloads are excessive. Individuals with SMI receiving inadequate or maintenance-only services, or with co-occurring substance use disorders or physical disabilities, require extra outreach and care coordination. Public mental health agencies must assure follow-along for individuals with SMI whose symptoms have improved, and must be cautious to not prematurely discharge them from service or impede an easy return to service simply because of administrative considerations. Better coordination of care must occur across CMHSP boundaries when individuals move to a location in a different catchment area so that the enrollment process is streamlined and necessary supports and services are not interrupted. Finally, the supports coordination/care management function needs to be vested with an expectation that coordination with primary health care will be a standard practice, assuring that individuals will have access to treatment of co-morbid conditions which can lead to increased physical disability and untimely death.

Dimension of Performance

1. *The applicant, and its affiliate CMHSPs as applicable, provides training, mentoring/coaching, supervision, and support (development time) to case managers and supports coordinators on:*
   a. *Local, state and federally funded programs and services.*
   b. *How to develop and access resources/consultation with other agencies and businesses in the community.*
   c. *How and when to access and consult with the resources ((e.g., psychologists, nurses, occupational/physical/speech therapists, and psychiatrists) that are available within the agency.*
2. *The applicant, and its affiliate CMHSPs as applicable, has collaborative arrangements in place including inter-agency agreements and coordination of care documents that address how multiple needs of individuals will be addressed; and how the effectiveness of the agreements will be evaluated..*
3. *The applicant, and its affiliate CMHSPs, as applicable, routinely assesses recipients' healthcare status, links them to the appropriate primary health care provider, and maintains communication with the primary health care provider.*

4. The applicant, and its affiliate CMHSPs as applicable, utilizes a process for engaging individuals in discussions about their health, and what changes in lifestyle or healthcare might be needed to improve their overall well-being.

MDCH expects that PIHPs will continue to be in substantial compliance with the standards relevant to this section, including the **EQR (**see Standard XIII, Coordination of Care)**, AFP (**see 2.9 Coordination and Collaboration, 3.4 Case management and Supports Coordination) and o**ther Medicaid, Mental Health Code and Contract requirements.**

9. Improving the Quality of Supports and Services

It is MDCH's goal to improve supports and services, and ensure that outcome measures that support community membership are identified and used. Supports and services must meet Medicaid standards, and all providers must meet qualification and credentialing requirements. Maximum staffing ratios for certain intensive services, such as case management, need to be established. Evidence-based, promising and best practices should be available to anyone receiving public mental health services. In particular, integrated treatment for co-occurring disorders should be available statewide, and each public mental health agency should employ peer specialists who have defined roles in the organization. Public mental health agencies should use measurement to determine whether the people they serve are achieving the outcomes they desire and take steps to continually improve supports and services when they find that achieving outcomes falls short. MDCH will work with public mental health agencies to improve their analyses of, and resulting actions to prevent reoccurrences of, sentinel events and critical incidents. MDCH will work with public mental health agencies to increase the involvement of individuals receiving services, their family members and advocates in the dialog, decision making, and evaluation of supports and services at all levels of the system.

Dimensions of Performance

People who receive services, their supporters (family, friends, and advocates), providers and other community stakeholders shall be involved in designing, implementing and evaluating these dimensions.

1. *The applicant, and its affiliate CMHSPs as applicable, routinely monitors and tracks the desired outcomes (that include community membership) for individuals receiving supports and services.*
2. *Using information from the outcomes monitoring and tracking, the applicant, and its affiliate CMHSPs as applicable, continually improves supports and services in order to achieve the desired outcomes for each person served.*
3. *The applicant has identified all the staffing ratios for case management and supports coordination services in its service area and is prepared to develop a plan for its service area to comply with maximum staffing ratios once standards are developed in FY 09.*
4. *Evidence-based, promising, and best practices are available within existing time and distance standards throughout the applicant's service area, including:*
    a. *Family Psycho-education (FPE)*
    b. *Integrated Dual Disorder Treatment (IDDT)*
    c. *Dialectical Behavioral Therapy (DBT)*
    d. *Assertive Community Treatment (ACT)*
    e. *Supported Employment for Adults with Serious Mental Illness*
    f. *Any other evidence-based, promising, or best practice (applicant to identify practices)*

5. *The applicant has empowered its improving practices leadership team and change agents that are implementing and overseeing a systems change process to support and expand integrated services for persons with dual disorders (MI/SUD).*
6. *The applicant immediately analyzes critical incidents and sentinel events that occur in its service area*
7. *The applicant requires and monitors quality improvements where it finds that critical incidents and sentinel events could have been prevented.*

MDCH expects that PIHPs will continue to be in substantial compliance with the standards relevant to this section, including the **EQR** (see Standards I, II, III, IV, VI, VII, and VIII), **AFP (**see 2.1 Stakeholder and Community Input, 2.7 Health and Safety, 3.5 Service Array, and 3.9 Quality Management), Quality Assessment and Performance Improvement Program, Attachment 6.7.1.1 of the **Contract and other Medicaid and Mental Health Code.**

10. Developing and Maintaining a Competent Workforce

Perhaps the most formidable barrier to achieving excellence in outcomes for persons who require intensive and ongoing support is to assure a stable, competent and sufficient workforce whose values, knowledge, skills, and abilities are developed and supported. This includes sufficiency in leadership and administration as well as in the provision of direct care, supports and clinical services.

Developing and maintaining a competent workforce involves:

- Leadership in guiding the organization's values, and in supporting diversity and inclusion
- Strategies for recruitment and succession planning
- Ongoing staff development and support (including training)
- Adequate supervision and accountability
- Consideration of workforce stability (retention) and the implications of training participation to service operations

Dimensions of Performance

Recruitment

1. *The applicant, and its affiliate CMHSPs as applicable, has processes in place to:*
   a. *Foster an understanding of the workforce needs of the public mental health system by university and community college educators, including participation in curriculum development, internship and other opportunities.*
   b. *Attract new employees.*
   c. *Attract a workforce that is representative of the community and the persons receiving services.*

Training and Staff Development

2. *The applicant, and its affiliate CMHSPs as applicable:*
   a. *Utilizes effective training technology, including: the need for leadership support in the adoption of new practices; the role of supervision in adopting and supporting the use of training opportunities; and implementation of necessary changes in agency policy and practices to support training as well as ongoing mentoring and other supports.*
   b. *Assures the availability of effective clinical and administrative support and supervision.*
   c. *Has processes in place to continually identify, train and provide support to staff on new evidence-based, best and promising practices.*

Monitoring and Accountability

3. *The applicant, and its affiliate CMHSPs as applicable:*

a. *Utilizes tools that reliably measure the ongoing competency of staff, including mechanisms to assess the technical assistance and training needs of all staff.*
b. *Takes into account the potential training costs and logistic demands over and above the contracted activities, in its development of training requirements for providers.*

MDCH expects that PIHPs will continue to be in substantial compliance with the standards relevant to this section, including the **EQR (**see Standard IV, Staff Qualifications and Training**, AFP (**see 3.4 Case Management and Supports Coordination) and **other Medicaid, Mental Health Code and Contract requirements.**

11. Achieving Administrative Efficiencies

It is an administrative responsibility that the public mental health system operate as efficiently and effectively as possible. Within the organizational structure of the PIHP and its affiliates, ongoing attention to and capacity for quality and process improvement and simplification is expected. Understanding individual, provider, stakeholder and staff experiences and involving them in such activities is essential. PIHP leadership must actively support such opportunities and provide guidance in the areas of paperwork reduction, Electronic Medical Records, understanding cost variability, reciprocity in training and service monitoring and uniformity in contracting.

MDCH will outline expectations for a locally-conducted examination of where a consolidation of functions, such as information systems, can be beneficial, especially within a PIHP affiliation or a multi-county CMHSP. MDCH will move to support development of electronic medical records technology within its capacities to do so. MDCH is also aiming to provide expectations for how much variability can be tolerated in the cost per unit of certain services. Finally, CMHSPs and PIHPs will be expected to work together to develop provider contracts and reporting protocols that contain common requirements and reciprocal recognition of provider training and monitoring.

Dimensions of Performance

1. *The applicant, and its CMHSP affiliates as applicable, employs continuous quality improvement methodology to improve, simplify and consolidate administrative functions in order to achieve efficiencies.*
2. *The applicant, and its CMHSP affiliates as applicable, has collaborated with the other PIHPs and their affiliates to develop provider contracts and reporting protocols that contain common requirements and reciprocal recognition of provider training and monitoring across geographic boundaries.*
3. *The applicant routinely analyzes the unit costs of the Medicaid services it provides, and its administrative costs, that are reported on each annual Medicaid Utilization and Net Cost report and compares them with statewide averages and other PIHPs' costs to look for opportunities for quality improvement.*

MDCH expects that PIHPs will continue to be in substantial compliance with the standards relevant to this section including the **AFP (**see 3.8 Provider Network Configuration, Selection and Management) and o**ther Medicaid, Mental Health Code and Contract requirements.**